GOPATH® DIAGNOSTICS

Genomic | Requisition form

Tel: 855.467.2849 | Fax: 224.588.9941 | Email: info@gopathlabs.com

PATIENT INFORMATION (Please print)

Name (Last, First) _____
Address _____
City, State, Zip _____
Phone # _____
☐ Male ☐ Female Date of Birth (MM/DD/YYYY) _____
Race/ Ethnicity ☐ White/Caucasian ☐ Black/ African American ☐ East Asian ☐ Hispanic ☐ Other _____
Diagnosis _____

ORDERING PHYSICIAN / LAB INFORMATION (Please Print)

Facility Name _____
Ordering Physician _____
NPI # _____
Address _____
City, State, Zip _____
Phone # _____ Fax # _____ E-mail _____

Billing information (Please provide copy of insurance card)

Primary Insurance: _____
(Please attach copy)
Bill: ☐ Insurance ☐ Medicare ☐ Medicaid ☐ Hospital ☐ Client ☐ Self Pay
Secondary Insurance: _____
(Please attach copy)
Place of Service: ☐ 21 - Inpatient Hospital ☐ 22 - Outpatient Hospital ☐ 11 - Office ☐ 24 - Ambulatory Surgery Ctr ☐ Clien Bill ☐ Outpatient

Coding information

Diagnosis Code/ICD-10 Code (Required): _____

The physician is required to document all applicable ICD codes or descriptions for all tests ordered supporting medical necessity which shall be used in patient plan of care. Example: ICD-10: Z80.0 (Family Hx of GI cancer)

COMMON ICD-10 CODES

Prostate: C61, D07.5, R97.2, Z15.03, Z80.42, Z84.81, Z85.46

Other required information

Genetic Conselor Requested: ☐ Yes ☐ No

Individual test options

GeneticsNOW® Series

☐ **PROSTATE***NOW*
☐ **BRCA***NOW*
☐ **LYNCH***NOW*
☐ **Comprehensive 88 Gene Panel**

Specimen retrieval

☐ Saliva ☐ Blood

Pathology Lab Name _____
Case number _____
Date of collection _____

OncoTarget® Series

☐ OncoTarget®500 *FDA Cleared Comprehensive Genomic Profiling*

Optional add-on tests:

☐ PD-L1 IHC* ☐ MMR IHC

* PD-L1 clone 22c3 is the default. For different clones please select all that apply

☐ 22c3 ☐ 28-8 ☐ SP142

Notes

Specimen retrieval

Option 1 ☐ Specific specimen requested *Please provide specimen details below*
Option 2 ☐ Let the submitting pathologist choose specimen
Option 3 ☐ Biopsy to be scheduled for: _____

Pathology Lab Name _____
Case number _____
Block # _____
Solid Tumor Collection Date _____

☐ Check here if the pathology lab is *not* part of the treatment team.

OncoTracking

☐ Special type

Optional add-on tests:

☐ PD-L1 IHC* ☐ MMR IHC

Specimen retrieval

OncoTracking Heme Panel

☐ Blood ☐ FFPE ☐ None Marrow

Section A must be completed for these options:

☐ Mobile phlebotomy ☐ Send saliva kit to patient

Please see specimen instructions for details

Date of collection _____

For provider

☐ Patient submitting for prior authorization with sample.
☐ ABN or Medicaid Waiver (if applicable)
☐ Patient Insurance card (front & back)
☐ Patient submitting for prior authorization without sample. Sample to be received: _____
☐ Patient Information & consent (required)

Physician Signature (required) _____

Patient Authorization

By signing this document, I authorize my provider to order this test. I understand authorization maybe required and is not a guarantee of payment by my insurance carrier. I understand that I may be contacted if there is an out-of-pocket payment.

Signature of Patient/Guardian(required) _____ Date _____ Phone number _____

To view reports, please visit www.gopathlabs.com and click Online Reporting

A. NOTIFIER: _____

B. PATIENT NAME: _____

C. ID NUMBER: _____

ADVANCE BENEFICIARY NOTICE OF NON-COVERAGE (ABN)

NOTE: If Medicare doesn't pay for D._____ below, you may have to pay. Medicare does not pay for everything, even some care that you or your health care provider have good reason to think you need. We expect Medicare may not pay for the D. _____ below.

D.	E. REASON MEDICARE MAY NOT PAY:	F. ESTIMATED COST
☐ **BRCA***NOW*® ☐ **BRCA***NOW*® Extended ☐ **LYNCH***NOW*™ ☐ **LYNCH***NOW*™ Extended ☐ **PROSTATE***NOW*™ Extended ☐ **DIABETES***NOW*™ ☐ **GENETICS***NOW*® **88 Gene Panel**	Patient does not meet Medicare coverage criteria	**$250**

What you need to do now:

- Read this notice, so you can make an informed decision about your care.
- Ask us any questions that you may have after you finish reading.
- Choose an option below about whether to receive the D. _____ listed above.

Note: If you choose Option 1 or 2, we may help you to use any other insurance that you might have, but Medicare cannot require us to do this.

G. OPTIONS: CHECK ONLY ONE BOX. WE CANNOT CHOOSE A BOX FOR YOU.

☐ OPTION 1. I want the D. listed above. You may ask to be paid now, but I also want Medicare billed for an official decision on payment, which is sent to me on a Medicare Summary Notice (MSN). I understand that if Medicare doesn't pay, I am responsible for payment, but I can appeal to Medicare by following the directions on the MSN. If Medicare does pay, you will refund any payments I made to you, less co-pays or deductibles.

☐ OPTION 2. I want the D._____ listed above, but do not bill Medicare. You may ask to be paid now as I am responsible for payment. I

☐ OPTION 3. I don't want the D. listed above. I understand with this choice I am not responsible for payment, and I cannot appeal to see if Medicare would pay.

H. ADDITIONAL INFORMATION:

This notice gives our opinion, not an official Medicare decision. If you have other questions on this notice or Medicare billing, call 1-800-MEDICARE (1-800-633-4227/TTY: 1-877-486-2048). Signing below means that you have received and understand this notice. You also receive a copy.

I. SIGNATURE: _____ **J. DATE:** _____

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